- The Trade and Sustainable Development Chapter proposal – in its cross-cutting part – contains provisions to ensure no relaxation of labour standards or environmental protection levels.

Legally binding

The EU has a clear stance on the Sustainable Development chapter being fully legally binding. As is normal practice in EU trade agreements, it intends to make it part and parcel of the agreement itself.

Enforcement

Mrs Malmström was clear when she said that ".. we are proposing a very ambitious approach to sustainable development in the EU-US trade talks, which will be respected, implemented and enforced when we sign up to them...."[227] Indeed, the EC asserts that the EU will work to ensure that all provisions of the Sustainable Development chapter are respected, implemented and enforced. Despite these statements, the exact enforcement mechanism is not yet detailed, which is a concern for civil society. As one civil society representative put it: "The EU is always full of lofty texts on labour and the environment, but enforcement is weak. While the US proposals contain strong enforcement mechanisms, of a not very ambitious sustainable development proposal".[228] The EU proposal on institutions and procedures still has to come: "Once the work on substance is in a more advanced stage, the Commission will make its proposals for institutional set-up, involvement of civil society and enforcement. In the meantime, discussions with stakeholders and civil society will continue."[229] This proposal, combined with the current ambitious proposal for Sustainable Development, will give more insight in how strong the total set of provisions in TTIP on Sustainable Development will be.

4.4.2. Case study 3: Impact of TTIP services liberalisation on public health services

Introduction

Healthcare services[230] are included in this TSIA as a separate case study for two reasons. Firstly, because various stakeholders clearly indicated the need to focus on the issue of access to healthcare services. Secondly, because there is a more general need to better understand the potential impact of TTIP on the provision of public health services in order to separate fact from fiction at a time of fierce public debates. In this case study we focus on how healthcare services could potentially be impacted by TTIP, by considering how the services liberalisation envisaged under TTIP – in large part through removal of NTMs such as regulatory divergence – could potentially affect public healthcare services. It is important to note that the EU approach to health services was established 20 years ago in the context of the General Agreement on Trade in Services (GATS) and the establishment of the World Trade Organization (WTO), and the EU will not change this approach for TTIP. This implies, among other things, that TTIP will not lead to changes in national legislation.

It should be noted that the case study focuses on services trade liberalisation under TTIP and not on the impact of tariff liberalisation on specific products used in healthcare services.

From the literature and our engagement with stakeholders it becomes clear that two main impact channels for how TTIP could impact on healthcare services need to be considered and assessed.[231] Firstly, the impact of possible entrance of private health care providers from the US

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227 Website DG Trade on the EU's new proposal to the US regarding the Sustainable Development chapter, DG Trade website, downloaded 19.11.2015.

228 Informal comment during the TSIA stakeholder scoping workshop on 9th of July 2015 in Brussels.

229 Website DG Trade on the EU's new proposal to the US regarding the Sustainable Development chapter, DG Trade website, downloaded 19.11.2015.

230 The WHO (2015) defines healthcare services as: Health services include all services dealing with the diagnosis and treatment of disease, or the promotion, maintenance and restoration of health. They include personal and non-personal health services and insurance is also included in our definition. The terminology 'public' health is much debated, since the healthcare sectors in various EU Member States are privatised.

231 During the 9 July 2015 and 21 September 2015 workshops with stakeholders, the potential channels of private health care providers as well as of regulatory chill from investor protection clauses were mentioned.

for EU healthcare services. Will this affect the provision of healthcare services in the EU and/or the access EU citizens have to healthcare services? Secondly, the potential for a 'regulatory chill' affect coming from regulatory cooperation and the Investor Protection mechanism that is being discussed. Will investor protection lead to regulatory chill that scares EU governments from changing healthcare policies for fear of company retaliations?

We first provide some background information as to how healthcare services are expected to be treated, in trade agreements in general and in TTIP in particular, followed by a description of the current healthcare system situation in the EU (a very fragmented picture). Combining these two sections, we assess potential impacts of TTIP in this area.

EU (Member States) and US Healthcare systems – the current situation

The EU Member States' healthcare systems

The EU Member States' various healthcare systems and their performance are subject to significant regulatory differences. In addition, the way in which health insurance is organised, as well as how hospital care is financed, varies considerably between EU Member States – e.g. public in the UK (National Health Service) and private in the Netherlands. Publicly financed healthcare systems are often divided into sub-sectors such as dental care, physiotherapy and general practitioners that may have different financing models. As Jeurissen (2010) confirms, it is important to note that only a small share of all hospitals in the EU operate for profit.[232] In order to provide an insight into the healthcare systems in the EU Member States – it is important to explore how they could potentially be affected by TTIP in the longer term – we have made a grouping of the EU Member State healthcare systems. Table 4.12 below provides a summary of the healthcare systems of 19 of the 28 EU Member States based on common organisational institutions according to Journard *et al.* (2010).[233] This is important in the context of the principle of subsidiarity (the power to regulate healthcare sectors at EU Member State levels) and the regulatory power that EU Member States maintain irrespective of any trade agreements, including TTIP. In other words: the effect of TTIP is likely to be asymmetric and depends on EU Member States' domestic healthcare systems and policies.

Table 4.10 Healthcare systems

Group	Characteristics	Countries
Group 1	Relies extensively on market mechanisms in regulating both insurance coverage and service provision. Gate-keeping[234] arrangements are in place.	Germany, the Netherlands, Slovak Republic
Group 2	Public basic insurance coverage and extensive market mechanism in regulating provisions. Differs per country in terms of degree of reliance on private health insurance to cover expenses beyond basic packages. Gate-keeping arrangements are in place.	Belgium, France
Group 3	Idem as Group 2, but without gate-keeping arrangements in place.	Austria, Czech Republic, Greece and Luxembourg.
Group 4	Regulatory rules provide patients with choice among providers; extremely limited private supply, also regarding insurance. No gate keeping in place. Prices tend to be highly regulated.	Sweden
Group 5	Heavily regulated public systems. Patients' choice is limited. Role of gate-keeping important. Public insurance, but private options available.	Denmark, Finland, Portugal and Spain.
Group 6	Heavily regulated public systems. Patients' choice tends to be large. Public insurance, but private options available.	Hungary, Ireland, Italy, Poland and the United Kingdom.

Source: Joumard et al (2010).

[232] Market share of FP hospitals (% of beds, 2005) Germany: 16% US: 14%, UK: 7% and Netherlands: 0%. Jeurissen (2010) *For Profit Hospitals: A comparative and longitudinal study of the for-profit hospital sector in four Western countries.*

[233] Joumard et al (2010) *Health Care Systems: Efficiency and Institutions*. OECD Economics Dep't Working Paper No. 769.

[234] A gatekeeper is a physician, typically a primary care physician (family practice, internist or pediatrician) who is responsible for determining a patient's primary services and coordinating the care so that appropriate services are given. In many insurance plans that have networks of hospitals and doctors, the primary care physician is the gatekeeper who provides referrals to specialists.

As demonstrated in Table 4.12, the mix of market instruments and regulatory approaches varies widely among EU Member States, from very heavily regulated public systems (with or without patient choice) to systems that rely more on market mechanisms. These differences, however, need to be viewed in a historical and institutional context per EU Member State and therefore cannot be taken to simply explain the effective outcomes of each of the healthcare systems. A system that has worked well in one EU Member State cannot simply be implemented in another and yield the same results. This means that, when it comes to potential impact of TTIP, we can only make more general inferences on potential effects, without reporting detailed impacts.

The US healthcare system

The Institute for the Study of Civil Society CIVITAS (Elliot Bidgood January 2013) points out that the health sector in the United States is characterised by a mix of public and private funding and provisions. In both the private and public sectors, medical services are generally regarded as high quality although the system is not without its problems, especially with regard to the access to health services. Insurance and coverage are, for example, limited compared with EU standards. In 2010 the Obama administration tried to address some of these problems with the Affordable Care Act (ACA), which has gone some way towards introducing universal medical care coverage in the US. Currently, two public healthcare programmes are dominant: Medicare and Medicaid. Medicare is the federal government's health programme that primarily serves Americans over the age of 65 and Medicaid is a joint federal-state programme principally designed to finance healthcare for people with lower incomes.

Besides these public programmes the US has private community-based 'Health Centres'. These centres are not-for-profit facilities that provide health care to uninsured citizens. Besides these services, the US is characterised by a private health system: in 2010 64 percent of the US population was privately insured and a small part is benefiting from an employer-provided health insurance.[235] The private health care sector is also called the 'managed care' system: healthcare providers do not set payment rates for individual services, but customise the bill per patient. In practice, this means that patients need verify with their health plan for approval before visiting a specialist or receiving a medical procedure.

Treatment of public services in TTIP

Public services in TTIP

It is important to note that we are discussing the healthcare sector as a public service in the EU. Also, the TTIP negotiations are ongoing and therefore no final treaty text is available. The EU's approach to protecting public services in TTIP and all other trade agreements has been largely the same over the 20 years since GATS.[236] Commissioner Malmström confirmed in early 2015 the EU's commitment to protecting public services in current and future free-trade agreements, including TTIP.[237] In all its trade agreements the EU takes a broad horizontal reservation that reserves the right to have monopolies and exclusive rights for public utilities in EU Member States at all levels of government (even if such public utilities are not publicly funded or do not receive state support in any form).[238] In addition, the EU retains certain reservations in its trade agreements for public services, on a sectoral basis (public education, public health and social services, and water). This means that public authorities at all levels do not have to treat foreign companies or individuals the same way as EU parties, and thus do not have to provide access to their markets.[239] But even without the above reservations and exceptions, EU trade agreements leave EU governments at all levels free to regulate all services sectors (private or public) in a non-discriminatory manner.

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235 US census bureau http://www.census.gov/hhes/www/hlthins/data/incpovhlth/2010/highlights.html.

236 http://trade.ec.europa.eu/doclib/press/index.cfm?id=1115.

237 Joint statements on public services by Malmström and Froman, http://europa.eu/rapid/press-release_STATEMENT-15-4646_en.htm; http://trade.ec.europa.eu/doclib/docs/2015/july/tradoc_153613.pdf; http://trade.ec.europa.eu/doclib/press/index.cfm?id=1115 http://trade.ec.europa.eu/doclib/docs/2015/march/tradoc_153266.pdf.

238 http://trade.ec.europa.eu/doclib/docs/2015/july/tradoc_153614.pdf.

239 Please refer to the following parts of the EU services offer:: P. 88, Annex II reservation number 20 on health and social services; P. 119, the EU's overarching reservation for public services from any market access liberalisation; P. 155, EU's reservation on privately funded health and social services.

Health services protected: public versus private

It is important to note that most countries in the EU have publicly financed healthcare systems. Nevertheless, some countries, including Germany, the Netherlands and Slovakia, have partly privatised healthcare systems. In the Netherlands, insurance companies are privatised and hospitals may in the near future become for profit organizations. Therefore these sectors are – at least in part – no longer 'publicly funded' (although we need to note that the term 'publicly funded' is applied very broadly: if a fully privatised UK hospital supplies services to the NHS and gets paid for it, the hospital falls under the definition of 'publicly funded'). Even if services are partially publicly funded, or receive state support in any other form, such as tax incentives, financial guarantees or indirect subsidies, they are excluded from the agreement. However, even 100 percent non-public services are regulated if part of an EU Member State's healthcare system, because an EU Member State, although it cannot discriminate based on nationality, can still heavily regulate also those private suppliers from abroad as long as this happens in a non-discriminatory manner. In other words, in theory health service providers from the EU and the US could come to compete with one another, but only within the framework set by the regulator. In fact, this has already been the case since GATS.

In previous trade agreements and partnerships, the EU has successfully negotiated four important guarantees for public health services. It is likely that the EU negotiators will uphold these in TTIP as well[240]:

1) ***Regulation***
   TTIP leaves governments free to regulate their public health sector and they can set their own quality standards that suppliers need to meet;

2) ***Access to the market***
   For public health services that receive public funding or support in any form, governments do not have to give access to service providers from outside the EU;

3) ***Monopolies***
   If they wish, national, regional or local governments can organise public services in such a way that only one supplier provides the service. The single supplier can be publicly owned as well as a private firm with the exclusive right to offer a particular service. And it can operate at any level – nationally, regionally or locally;

4) ***Subsidies***
   EU governments at all levels are free to provide subsidies to the public health sector. On top of that, governments will not have to treat companies from outside the EU in the same way as EU businesses. This means that governments can actually exclude non-EU companies from such subsidies if they wish.

Furthermore, TTIP will not contain a "ratchet" clause for public services whereby services that are "privatised" cannot be returned to a public monopoly following a change of political direction. A ratchet clause means that a contracting party cannot backtrack from any future autonomous level of liberalization irrespectively of what was bound in the trade agreement.

Potential impact of TTIP on public health services

Now that we have summarised differences in EU Healthcare systems and stipulated what may be expected to be included in the TTIP agreement regarding public services in general and more specifically regarding public health services, we can turn to what impacts from TTIP for EU Member States' health care services are to be expected.

Private health services and TTIP

Civil society groups are concerned by the fact that the EU has never explicitly defined the concept of 'state support'.[241] In particular, the text of the reservation refers to "state support in any other form" and as such seem to be a very broad exclusion giving sufficient flexibility in capturing all current and future health systems in various member states, even if these services

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[240] European Commission (3rd of July 2015) Protecting public services in TTIP and other EU trade agreements. http://trade.ec.europa.eu/doclib/press/index.cfm?id=1115.

[241] Civil society Dialogue Meeting on TTIP and Health, 27 May 2015 (Brussels) as well as feedback during the 9 July and 21 September 2015 workshops with civil society about this case study (and other case studies) for the TSIA.

are supplied by a variety of providers (including private parties) and if they have commercial aspects (even though they are not meant for profit generation). However, civil societies consider that this language is not precise enough and this causes uncertainty with regard to the protection of 'public' services. At the same time we are not aware of any specific examples which could demonstrate that there are health services in the EU which would not receive any state support and where the EU would like to retain the right to discriminate based on nationality.

We already stipulated that TTIP is not going to require any changes to EU laws and practices (legislation is not amended) related to the health sector. Hence, the impact of TTIP on the provision of public health services in the EU is difficult to predict. On the one hand, we have encountered clear words from negotiators and the European Commissioner for Trade, Mrs Cecilia Malmström that public health services will be and are protected in the TTIP negotiations. The definition of public health services remains a source of uncertainty for civil society organisations. If defined narrowly (i.e. private healthcare services are excluded), some health care services may be affected by potentially heightened competition from non-public US health services.[242] It is important to note, however, that the degree to which this increased competition can affect domestic EU Member State health care services depends on the regulations in place per EU Member State (i.e. how healthcare systems are organised domestically).

TTIP itself will not open up the health care market, which is why it will be difficult to attribute effects on EU health services squarely to TTIP. A key determinant is whether EU Member States will allow private US healthcare providers onto their domestic markets as this is their prerogative: the EU Member State governments are in the driving seat here. Civil society organisations like EPHA and EPSU fear that when TTIP states that Member States need to open up their healthcare markets, the principle of subsidiarity could be circumvented. As a result, they fear that TTIP will result in increasing pressure to privatise healthcare services, which might also affect the performance of healthcare services.[243] However, at this stage these seem unfounded fears since EU's current offer states how each Member State has decided to limit, or even deny, access to private healthcare services onto their local markets. Furthermore, there are no provisions in TTIP that would require EU governments to privatize public services or to bring them back into public domain once they were privatized.

Regulatory co-operation and investor protection

Civil society organisations are very concerned that regulatory co-operation and a form of Investment Protection and/or possibly some form of investor-state dispute settlement (ISDS), may eventually have an indirect impact on the provision of public health services in the EU through the possibility of 'regulatory chill' with respect to health policies.

Regulatory co-operation

Regulatory coherence is an important element of TTIP that sets this trade agreement apart from previous ones (with perhaps the exception of the Comprehensive Economic and Trade Agreement, CETA between Canada and the EU). TTIP has high ambitions for reaching more regulatory coherence but within certain boundaries. It aims to "*reduce unnecessarily burdensome, duplicative or divergent regulatory requirements affecting trade or investment [....], without restricting the right of each party to maintain, adopt and apply timely measures to achieve the [overall] legitimate public policy objectives*"[244]. This statement is preceded by: "*while pursuing a high level of protection of [...] consumers, [...] human, animal and plant life, health and safety;*

[242] It is important to take notice of the limited health care globalization. We did not find significant evidence of health service providers operating in both the EU and in the US, except of pharmaceutical companies and medical device producers.

[243] Both the European Public health Alliance (EPHA) and the European Public Services Union (EPSU) have made content submissions that express their fears of a TTIP-induced pressure to privatise public health care services and a pressure not to re-nationalise privatized health care services.

[244] European Commission, DG TRADE, 2015, *Textual proposal for legal text on Regulatory Cooperation in TTIP*, May 2015.

[...]"[245]. The preamble to the regulatory co-operation Chapter states clearly that regulatory cooperation is to take place without challenge to each party achieving its desired public policy objectives, in particular while pursuing a high level of protection of health and safety. When looking at the various ways in which regulatory co-operation is pursued – ranging from information exchange, using international agreements together, mutual recognition agreements of conformity assessments or of test results, to mutual recognition of functionally equivalent technical requirements or harmonised technical regulations – there is no tool where TTIP is meant to 'legislate'. That is clearly the prerogative of the US and EU (and EU Member States) domestic law-making systems. As such, regulatory cooperation cannot impose any changes to EU Member State or the US domestic health care system.

Investment protection and resolution of investment disputes[246]

We often hear – and this is also a major concern communicated by various stakeholders – that Investor Protection clauses and Resolution of Investment Disputes could be the cause of a so-called 'regulatory chill' for governments. In July 2015 the European Parliament (EP) has adopted its recommendations to the commission on TTIP. The EP has called for a mechanism that would be "subject to democratic principles and scrutiny" and where cases would be dealt with by "publicly appointed, independent professional judges [in] public hearings", reads the text.[247] There had previously been fears that investment protection would rely on private arbitration, giving corporations too much power over national governments. The latest EU proposal stipulates that EU Member States will continue to be able to legally govern their public services and, for example, decide to privatise or reverse privatisation of public services as they see fit – based on the guarantees negotiated at the inception of GATS in 1995. The inclusion of Investor Protection in its pre-CETA form could possibly lead to the fear of being sued by investors and thus could indirectly prevent EU Member States from implementing new policies and (reverse) privatization. The latest EU proposal to the US on Investor Protection (IP) and Investment Court System (ICS) is fundamentally different, however, even from the CETA text. IP is much more narrowly defined and eligibility of a case is subject to very clear and strict criteria first. ISDS is withdrawn in favour of ICS – with clearly a different process, including the right to appeal.[248] Article 3 of Regulation 1219/2012, establishes transitional arrangements for bilateral investment agreements between Member States and third countries. This Regulation stipulates that bilateral investment agreements between EU Member States (read: employing the 'old' IP and ISDS provisions) and the US can be maintained in force only until they are replaced by an agreement at the EU level (read: until TTIP comes into force).

The many uncertainties regarding the final agreement make it still difficult to predict the final outcome of TTIP for public health services. However, if CETA were to be the benchmark for TTIP on how to treat and protect public services, no major impact on EU Member States' health care systems is to be expected – which is in concordance with the EU treaties on subsidiarity. This means that civil society's concerns regarding the definition of public services in the context of TTIP are unnecessary.

Concluding remarks

All countries in the EU have some form of state-supported healthcare system, and the current trend of liberalisation does not seem to be changing this. Furthermore, TTIP may not increase competition for (non/semi-) public health services, for the simple fact that TTIP will not include any additional obligations as compared to the EU's GATS commitments and as such will not require EU governments to change their laws. Besides, it remains up to the sovereignty of EU Member States whether or not to allow other healthcare providers to enter their market. TTIP would only open the door to more competition if the EU Member State authorities allow it to, but this might happen autonomously irrespectively of trade agreements pursued by the EU.

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[245] European Commission, DG TRADE, 2015, *Textual proposal for legal text on Regulatory Cooperation in TTIP*, May 2015.

[246] Based on the document which is the European Union's proposal for Investment Protection and Resolution of Investment Disputes. It was tabled for discussion with the United States and made public on 12 November 2015. The actual text in the final agreement will be a result of negotiations between the EU and US.

[247] https://www.theparliamentmagazine.eu/articles/news/ttip-eu-parliament-vote-paves-way-new-isds.

[248] The "right the regulate" provision is stated in Article 2.1 of the EU draft TTIP investment text, and reads: *The provisions of this section shall not affect the right of the Parties to regulate within their territories through measures necessary to achieve legitimate policy objectives, such as the protection of public health, safety, environment or public morals, social or consumer protection or promotion and protection of cultural diversity.*
http://trade.ec.europa.eu/doclib/docs/2015/september/tradoc_153807.pdf.

To conclude, it seems that EU's trade agreements provide guarantees for the protection of public services. TTIP is not expected to deviate substantially from previous trade agreements.

- First, TTIP will not include any additional obligations as compared to the EU's GATS commitments;
- Second, healthcare systems vary considerably across the EU, but despite this, there is no evidence that any of the EU's Member States would require more protection as it is afforded by the current EU's approach to health services in trade agreements;
- Third, it is important to take into consideration that harmonization of healthcare systems in the EU is not anticipated and the principle of subsidiarity is firmly protected by the EU treaty;
- Finally it is important to recognise that, if not properly excluded from the Investor Protection articles, a form of Resolution of Investment Disputes could be the cause for 'regulatory chill' among governments. The risk of regulatory chill is mitigated by the new proposal on Investment protection/ ICS. If public health services are carved out from Investor Protection – i.e. investors cannot claim any compensation for public authorities' decisions to carry out changes in public healthcare systems – then the risk for 'regulatory chill' would be further reduced, if not completely removed.

4.4.3. Horizontal issues

In this section we shortly address some of the key aspects of the ILO Decent Work Agenda. As the fundamental labour rights, social protection and employment creation are already discussed above we will only discuss occupational health and safety, gender equality and social dialog here.

Occupational health and safety

The ILO has held many conventions on occupational health and safety, such as the Occupational Safety and Health Convention of 1981 (n0. 155) and sector wise there were occupational safety and health (OSH) conventions for dock work, constructions, mining and agriculture.

The ILO estimated that 4percent of Global GDP is lost due to poor OSH practices. A Global Strategy to improve occupational health and safety was adopted in 2003. This global OSH strategy is build on national preventative safety and health cultures and a systems approach to OSH management.

In the EU there is the European Agency for Safety and Health at work trying to improve working condition in Europe (www.osha.europa.eu). The Agency runs from time to time questionnaires on general OSH risks and how they are managed. In the US there is the OSH Administration as part of the US Department of Labor that aims to assure the safe and healthful working conditions of working people (www.osha.gov).

Gender equality

The ILO has since its mandate in 1919 been active on equal remuneration for work by men and women. In the EU gender equality has been a founding principle with 'equal pay for equal work'. Within the framework of the EU 2020 Strategy, a Strategic engagement for Gender equality 2016-2019 was released in December 2015 with the following five existing thematic priority areas:

- Increasing female labour market participation and the equal economic independence of women and men;
- Reducing the gender pay earnings and pension gaps and thus fighting poverty among women;
- Promoting equality between women and men in decision making;
- Combatting gender-based violence and protecting and supporting victims;
- Promoting gender equality and women's right across the world.

The Obama government is promoting gender equality as well as women's empowerment.